

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23812  
REG. NO.

235167

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN THE CIRCLE IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS OF DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Orlena	MIDDLE Brombley	LAST Burke	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH X 8	DAY 14	YEAR 1985	10:00 A M	
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH 1 YEAR 75	6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	7 IF UNDER 1 YR. MONTHS 0	8 IF UNDER 24 HRS. DAYS 0	9c. DATE PRONOUNCED DEAD	MONTH 8	DAY 14	YEAR 1985	10:00 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED WIDOWED X			9. BALTIMORE CITY OR COUNTY OF DEATH Somerset		
10. CITY OR TOWN OF DEATH Princess Anne			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kings Creek Trailer Ct.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Rt. 1 Princess Anne		
13a. STATE MD	13b. COUNTY Somerset	13c. CITY OR TOWN Princess A.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 1 Princess Anne					
14. FATHER'S NAME FIRST Thomas			15. MOTHER'S MAIDEN NAME FIRST Margie			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 199-24-5446		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MI			17. INFORMANT Dorothy Taylor Princess Anne, MD			ADDRESS 209 Payne Ave.			APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH Chatham		
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.			DUE TO, OR AS A CONSEQUENCE OF Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>James A. Sterling</i> M.D. TITLE (SPECIFY) <i>M.D.</i> MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT)		EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 320 West Main Street Crisfield			DATE SIGNED 8/15/85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-17-85		23c. NAME OF CEMETERY OR CREMATORIAL Olivet Cemetery			23d. LOCATION CITY OR TOWN Eden		COUNTY Worc.	STATE MD	
24. FUNERAL DIRECTOR <i>James L. Linnan, Princess Anne MD</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG 20 1985			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>		

SUBJ

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225043

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

23813

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			Martha	M.	Byrd	8-6-85				1:45a	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Feb. 10, 1930		55		MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Tenn.		U. S. A.				Somerset					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Crisfield		Edw. W. McCready Mem. Hospital				Housewife		- - - -			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Somerset		Crisfield				Rt. 2-Box 11A-Byrd Rd. (21817)			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Walker		Patterson		Sandlin, Sr.		Mataleena				Bennett	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
no			415-42-5871			Merrill O. Byrd, Jr.			Same as 13 a,b,c,d,e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>GRAM NEGATIVE SEPTICEMIA</u> 10 HRS											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>URINARY TRACT INFECTION. KLEBSIELLA</u> <u>PNEUMONIA</u> 3 DAYS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>DIABETES MELLITUS; VENTRAL HERMIA; CHOLELITHIASIS</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>AUG. 2, 1985</u> to <u>AUG. 6, 1985</u> , that (I) (we) last saw the deceased alive on <u>AUG. 6, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.											
22b. SIGNATURE <i>Greg Belloso, M.D.</i>		DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>AUG. 6, 1985</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Dr. Greg Belloso						McCready Hospital, Crisfield, Md. 21817					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Burial		8/9/85		Sunnyridge Cemetery		Crisfield		Somerset		Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Bradshaw & Sons, Main St., Crisfield, Md.						AUG 9, 1985					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Code 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

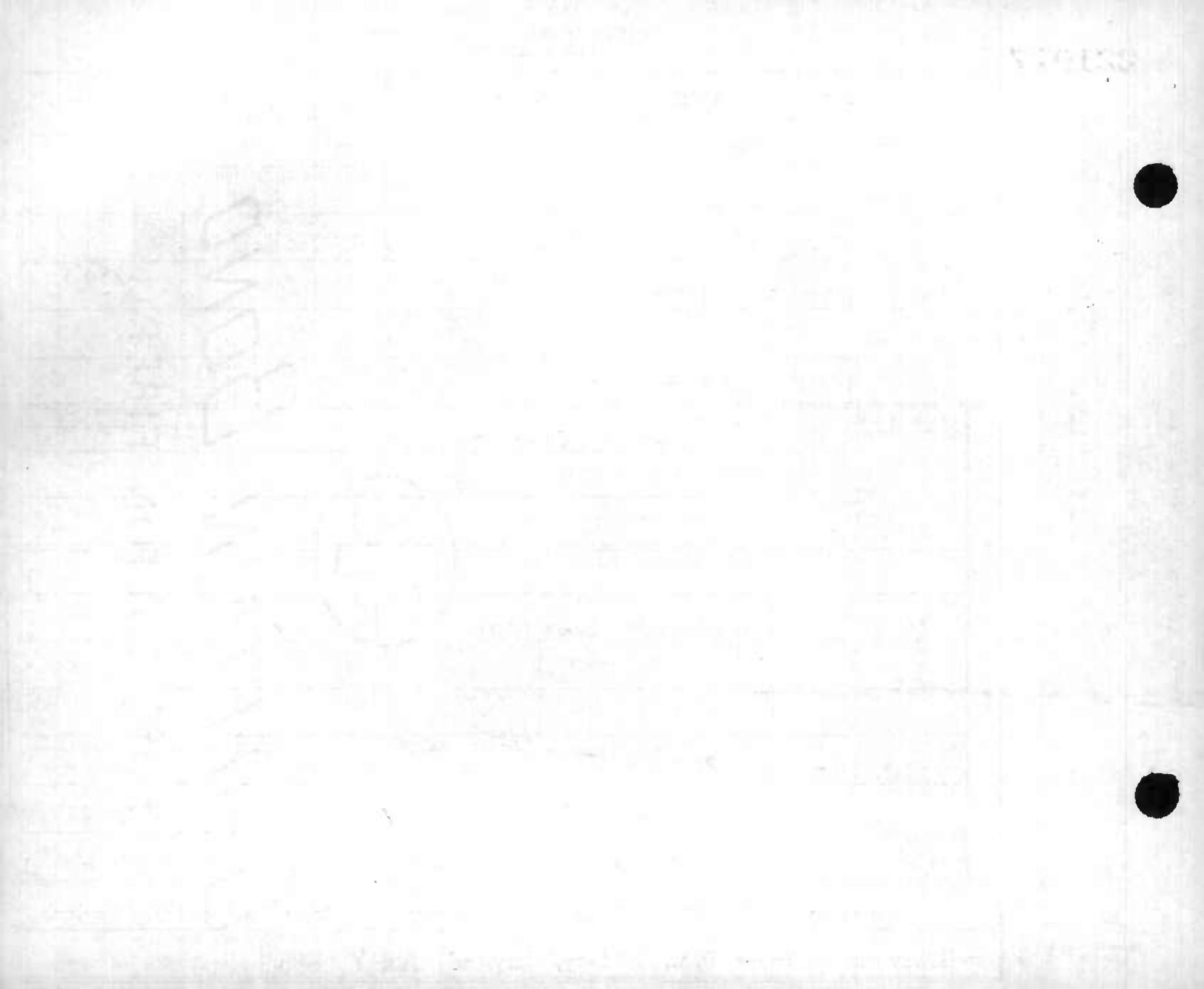


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full in the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 must be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical committee must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23814			
												REG. NO.			
1. FOR STATE REGISTRAR			2. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			2b. HOUR			
			George William Conklin, Sr.						August 4, 1985			0100 M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		MONTH 03 DAY 27 YEAR 1913			72			MONTHS	YEARS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
New York		U.S.A.					SOMERSET								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
PRINCESS ANNE		ROUTE #1 CROWSFOOT LANE										Retired Carpenter		21853	
13a. STATE Maryland		13b. COUNTY Somerset		13c. CITY OR TOWN Princess Anne			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS Route #1 Crowsfoot Lane					
14. FATHER'S NAME FIRST Mortimer			MIDDLE H.			LAST Conklin			15. MOTHER'S MAIDEN NAME FIRST Rose			MIDDLE Baker		LAST Mott	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT Mrs. Ruth Conklin (Wife) Same as #13e			ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			578-09-2205												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LUNG CANCER</u>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION 7/15/85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Biopsy of Lung mass			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
✓ 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 8/5/1985			
22b. SIGNATURE Will B. Furlong M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William B. Furlong M.D.			22e. ADDRESS Mt Vernon Rd. Princess Anne, Md. 21853												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8/4/1985			23c. NAME OF CEMETERY OR CREMATORY Salisbury Crematory			23d. LOCATION CITY OR TOWN Salisbury, Wicomico, Maryland			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A., Salisbury, Maryland			25a. DATE REC'D. BY REGISTRAR AUG 7 1985			25b. REGISTRAR'S SIGNATURE									
DHMH-16 30M 2/B0 (VRA 15, 4)															



221079

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 23815

REG. NO.

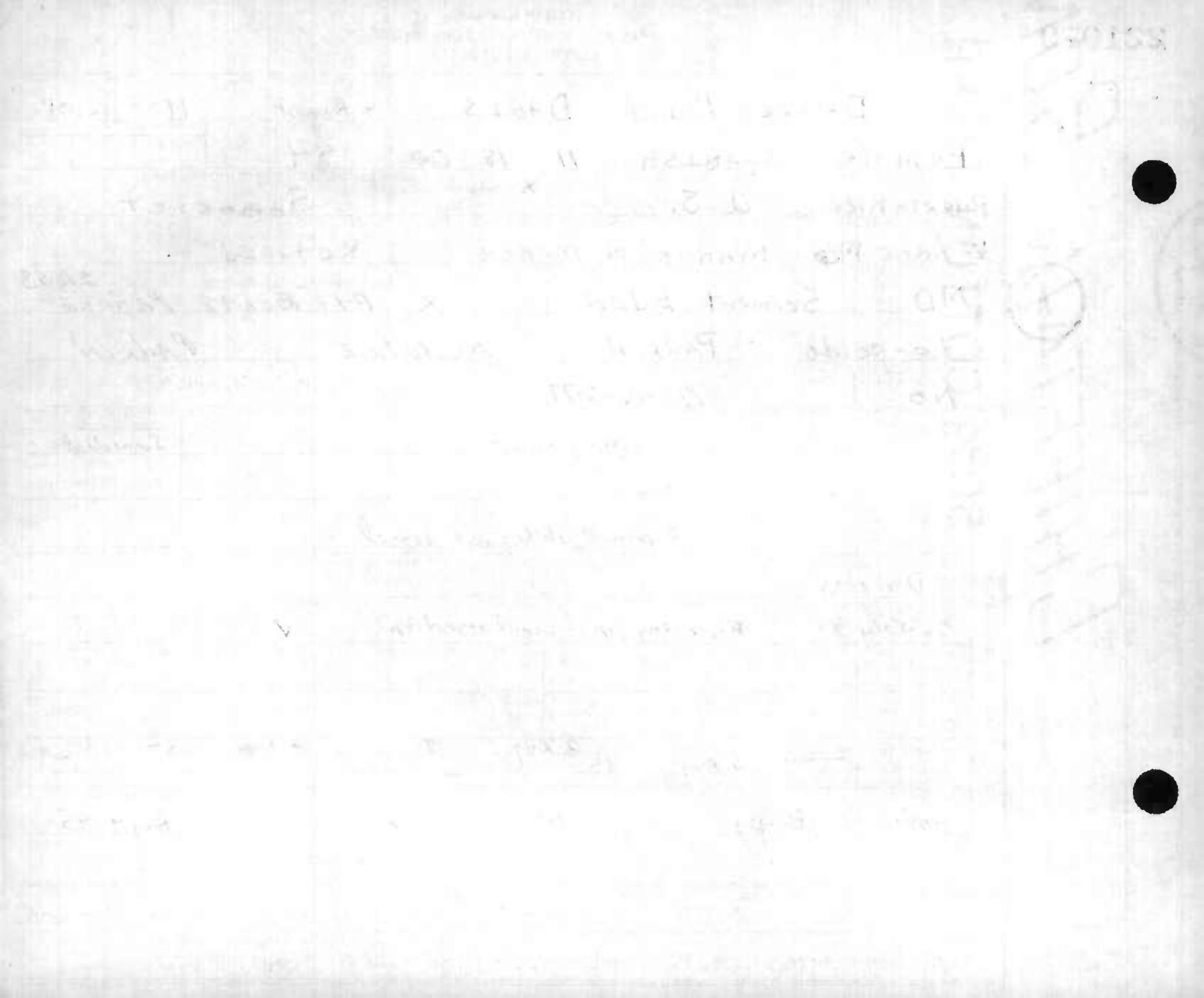
1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Dolores Padron			DAVIS			4 August	1985			12 10 P.M.		
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		
Female			Spanish	MONTH	DAY	YEAR	84			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Puerto Rico			U.S. A.						Somerset			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Pr. Anne Md			Manokin Manor			Retired						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
13a. STATE MD			13b. COUNTY Somerset			13c. CITY OR TOWN Eden			21853			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
Leopoldo				Padron	Medelice				Padron			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			192-16-2877			Same as #13e Mr. Milton Davis, Husband			Immediate			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Shock</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ruptured abdominal vessel</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Diabetes</u>												
19a. DATE OF OPERATION 26 July 85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Exploratory lap-sigmoid resection</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3 Aug 1985</u> to <u>4 Aug 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <u>4 Aug 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Lelelo O. Hargy</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Aug 4 85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Manokin Manor, Princess Anne, Md. 21853						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8/5/1985			23c. NAME OF CEMETERY OR CREMATORIAL Salisbury Crematory			23d. LOCATION CITY OR TOWN Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR Holloway Funeral Home, P.A., Salisbury, Maryland			25a. DATE REC'D. BY REGISTRAR AUG 7 1985			25b. REGISTRAR'S SIGNATURE <u>John</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/trust permit. Then please remove carbon from page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

235062

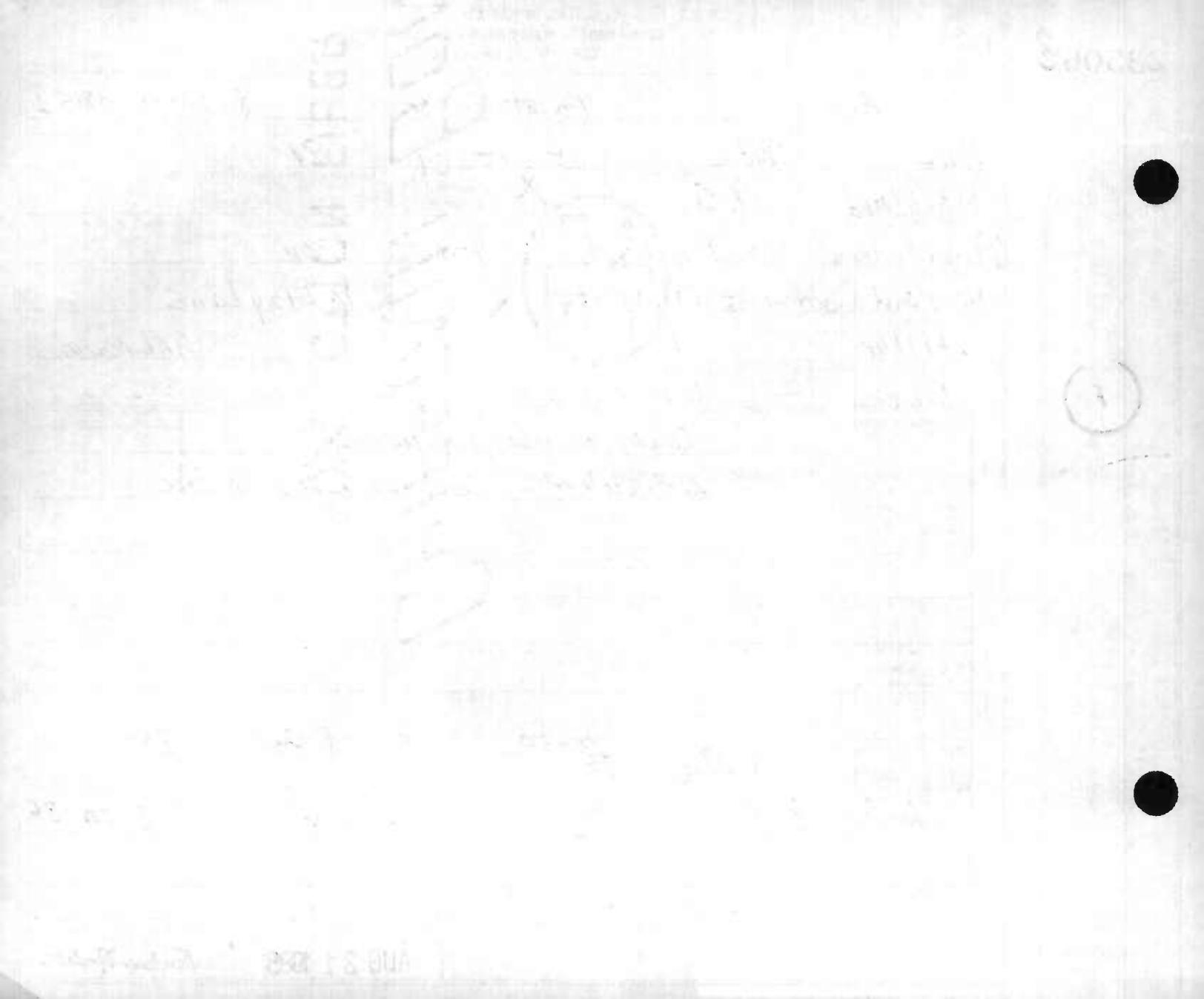
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

23816

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
George					Fountain Sr.	8-20-85				0815 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male		Black		MONTH	DAY	YEAR	84	YRS	MONTHS	DAYS	IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.						Somerset County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Princess Anne		Honakin Manor Nsg Home			Cook			21817			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland		Somerset		Crisfield		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			16 Eazy Lane 21817		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	
Arthur				Fountain						Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
Unknown		—		169-10-0936		George Fountain Sr.			Phila. Pa.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cerebrovascular Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. SIGNATURE <u>Charles Stegman</u> MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED <u>8-20-85</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>8-24-85</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Liberia Cemetery</u>			23d. LOCATION CITY OR TOWN <u>MARION</u>		COUNTY <u>SOMERSET</u>		STATE <u>MARYLAND</u>
25a. DATE REC'D. BY REGISTRAR <u>AUG 21 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Sylvia Davidson Pendell</u>									
FOOKS FUNERAL HOME WEST RD. & BOOTH ST. SALISBURY, MD 21801 ADDRESS											



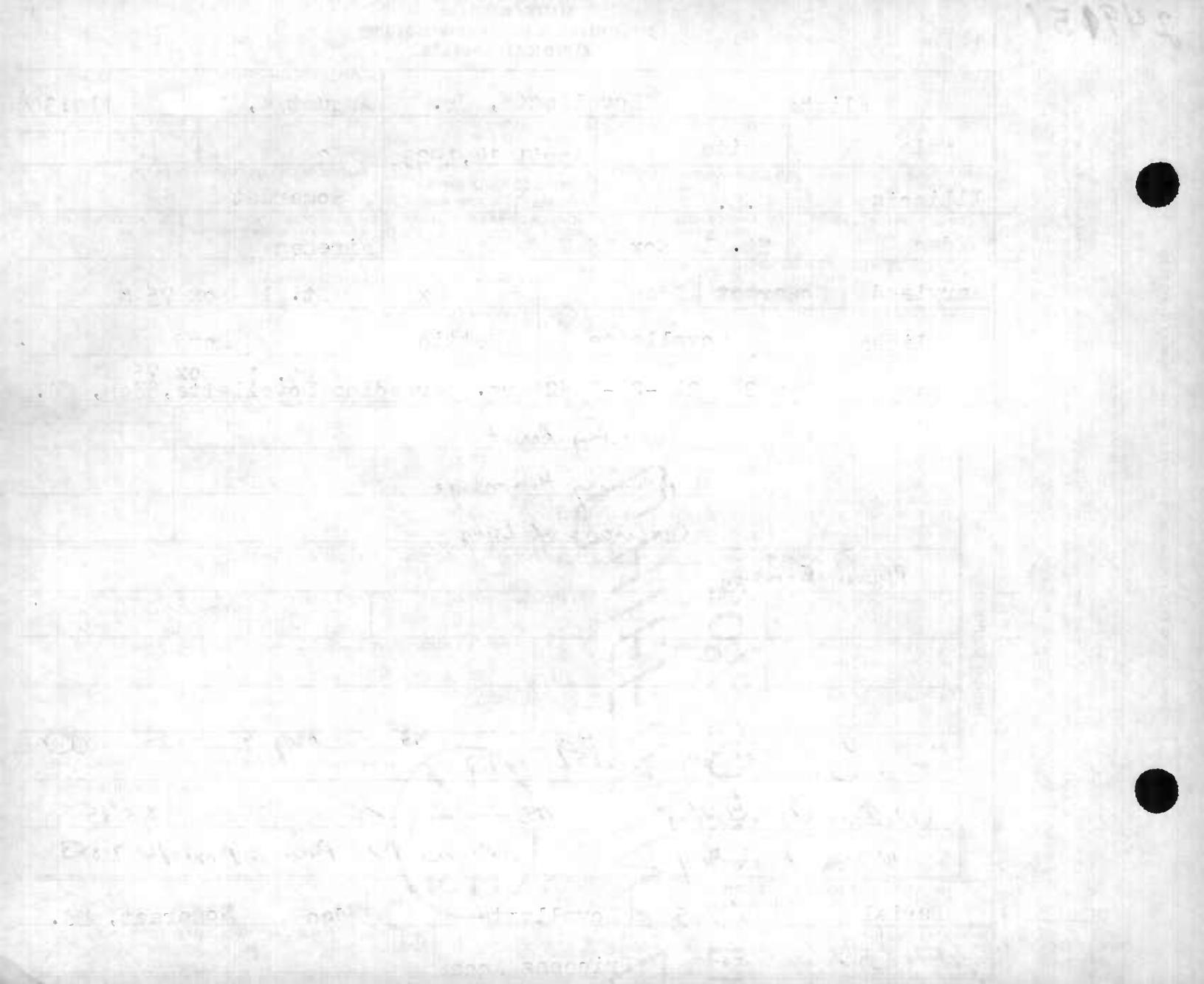
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23811								
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Elisha									Lovellette, Jr.			August 4, 1985						10:30A		
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White			MONTH DAY YEAR						April 14, 1923			62	YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH											
Illinois			U.S.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Somerset											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Eden			Rt. 1 Box 75 E						Fireman											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Maryland			Somerset			Eden			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 1			21822					
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME											
Elisha						Lovellette			Hattie			Ford								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS											
Yes			War 2 217-26-3852						Mrs. Bernadine Lovellette, Eden, Md.			Rt. 1 Box 75 E								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DOES NOT EXIST																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															(b) <i>Pulmonary Hemorrhage</i>					
DOES NOT EXIST															(c) <i>Carcinoma of Lung</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Pleural Effusion</i>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE								
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>May 31 1985</i> to <i>Aug 4 1985</i> , that <input type="checkbox"/> (we) last saw the deceased alive on <i>July 19 1985</i> , and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.																				
22b. SIGNATURE <i>William A. Godfrey</i>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/5/85											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William A. Godfrey</i>			22e. ADDRESS 17 Vernon Rd Princess Anne Del 21853																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/6/85			23c. NAME OF CEMETERY OR CREMATORIAL Lovellette			23d. LOCATION CITY OR TOWN Eden			COUNTY STATE Somerset, Md.								
24. FUNERAL DIRECTOR NAME <i>James L. Newman</i>			ADDRESS Princess Anne			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>James L. Newman</i>											



256030  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used for a burial-trousser permit. If Rogers (and 2) with the State Department of Health, add 72 hours after death.

VR A15ME (5)  
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

65 23318

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- MATED	Month	Day	Year	2b. HOUR	
Elouise			H.		Miles	8	31	1985	3P M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years at death)	IF UNDER 1 YEAR	IF UNDER 24 HRS						
F	AA	11-17-1925	59 yrs.	MONTHS	DAYS	HOURS	MIN				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	WIDOWED	DIVORCED	9. COUNTY OF DEATH				
Md		USA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Somerset				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Pr. Anne			255 Beckford Ave, Nurses Aide			Nurses Aide					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS			13e. STREET AND NUMBER		
Md			Somerset, Pr. Anne			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			255 Beckford Ave, Pr. Anne Md		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Edward S.					Hurman	Minnie					Toadine
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
(If yes give war service of service)			182-20-3527			Ernest H. Miles			255 Beckford Ave, Pr. Anne Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>Acute My</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a). stating the <u>underlying cause</u> (b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
short											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						2d. AUTOPSY?		
									YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town	County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James A. Sterling</u>											
EXAMINER'S NAME (Type) <u>James A. Sterling, Jmd</u>											
23a. BURIAL/CREMATION REMOVAL (Specify)			23b. DATE <u>9/7/85</u>			23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>			23d. LOCATION (City or Town) <u>Pr. Anne</u> (County) <u>Som. Md.</u> (State)		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR DATE <u>SEP 06 1985</u>			25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>		
Addie Janes 407 Somerset Ave. Pr. Anne Md.											

2025

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235101

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

23819

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST <i>Robert</i>	MIDDLE	LAST <i>Miles</i>	2a. DATE OF DEATH <i>08/13/85</i>	MONTH	DAY	YEAR	2b. HOUR <i>2:44 PM</i>	
3. SEX <i>Male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH <i>06</i> DAY <i>17</i> YEAR <i>95</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS.			IF UNDER 1 YEAR MONTHS <i>0</i>		IF UNDER 24 HRS HOURS <i>2</i> MIN. <i>4</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>US</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Somerset Co.</i>			MD.				
10. CITY OR TOWN OF DEATH <i>Princess Anne</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Merrick Manor</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Somerset</i>	13c. CITY OR TOWN <i>Crisfield</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>33 Somers Cove</i>						
14. FATHER'S NAME <i>Robert</i>	MIDDLE	LAST <i>Miles</i>	15. MOTHER'S MAIDEN NAME <i>Sarah</i>			MIDDLE			LAST <i>Unknown</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>	16b. SOCIAL SECURITY NO. <i>80-301977-000</i>	16c. DATE OF DEATH <i>Mar. 3, 1919</i>	17. INFORMANT <i>Kurette Miles</i>			ADDRESS <i>33 Somers Cove Crisfield Md.</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CHF</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCD</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>C. Stegman MD.</i>				DEGREE				22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>Aug. 17, 1985</i>				23d. LOCATION CITY OR TOWN <i>Marion</i>				
24. FUNERAL DIRECTOR <i>Norma J. Ward Marion Sta., Md. 21833</i>				23e. NAME OF CEMETORY OR Crematory <i>John Skoddy</i>				23f. COUNTY <i>Somerset</i>				
BP_____				25a. DATE REC'D. BY REGISTRAR <i>AUG 20 1985</i>				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>				
DHMH - 16 60M 7/84 (VRA 15, 4)												

102 386

248127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

23820

REG. NO.

X DECEASED NAME (TYPE OR PRINT)			FIRST EUTHA	MIDDLE M.	LAST STERLING	2a. DATE OF DEATH 08 28 85	MONTH DAY YEAR	2b. HOUR 6:15P	
3. SEX FEMALE			4. RACE WHITE		S. DATE OF BIRTH MONTH 04 DAY 10- YEAR 12	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH SONERSET			
10. CITY OR TOWN OF DEATH CRISFIELD			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ALICE BYRD TAWES NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY At Home		
13a. STATE MARYLAND	13b. COUNTY SOMERSET	13c. CITY OR TOWN CRISFIELD			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 63 SOMERS COVE APTS./ 21817			
14. FATHER'S NAME FIRST Edward			MIDDLE Sterling	LAST	15. MOTHER'S MAIDEN NAME FIRST Jessie	MIDDLE Purcell	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-12-4132		17. INFORMANT Peggy DeHaven - Rt. 1 - Box 413/ MD 21817	ADDRESS Crisfield,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Ca</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Colon Ca</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>04-03</u> , 19 <u>85</u> , to <u>08-28</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>08-28-</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>C. J. Huddleston</u>			DEGREE			ATTENDING, MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C. J. Huddleston</u>			22d. ADDRESS <u>McCready Hoop, Crisfield, MD 21817</u>			22e. DATE SIGNED <u>8/28/85</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/85	23c. NAME OF CEMETERY OR CREMATORIAL Asbury Cemetery		23d. LOCATION CITY OR TOWN Crisfield - Somerset - MD		23e. COUNTY STATE		
24. FUNERAL DIRECTOR NAME Bradshaw & Sons / Crisfield, MD			ADDRESS 21817		25a. DATE REC'D. BY REGISTRAR SEP 3 1985	25b. REGISTRAR'S SIGNATURE <u>Wendell</u>			

001849

Month	Actual	Forecast	Budget
January	1,28	1,28	1,28
February	1,28	1,28	1,28
March	1,28	1,28	1,28
April	1,28	1,28	1,28
May	1,28	1,28	1,28
June	1,28	1,28	1,28
July	1,28	1,28	1,28
August	1,28	1,28	1,28
September	1,28	1,28	1,28
October	1,28	1,28	1,28
November	1,28	1,28	1,28
December	1,28	1,28	1,28

A

254038

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

23821

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Jennings	MIDDLE Tankersley	LAST	2a. DATE OF DEATH MONTH 8-30-85	DAY 8	YEAR 1985	2b. HOUR 24MM		
3. SEX Male			4. RACE White	5. DATE OF BIRTH MONTH March 21 1900 YEAR		6. AGE 85 YRS.	7. IF UNDER 1 YEAR MONTHS 0		8. IF UNDER 24 HRS HOURS 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Somerset County					
10. CITY OR TOWN OF DEATH Deal Island			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RFD mail carrier - Postal					
13a. STATE Md			13b. COUNTY Somerset	13c. CITY OR TOWN Deal Island	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Wheatley Road - 21821				
14. FATHER'S NAME FIRST William			MIDDLE J	LAST Tankersley	15. MOTHER'S MAIDEN NAME FIRST Maggie		MIDDLE A	LAST White			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. no			17. INFORMANT Eleanor Bicking, Deal Isl., Md. 21821		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cardiac Arrest						Minutes		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DOUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis						years		
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 5-4-76 to 8-30-85, that (I) (we) last saw the deceased alive on 8-29-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											22c. DATE SIGNED 9-2-85
22b. SIGNATURE Everett C. Sutter			22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS Dames Quarter, Md. 21820					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 9/3/85			23c. NAME OF CEMETERY OR CREMATORIAL St. John's Cemetery			23d. LOCATION CITY OR TOWN Deal Isl., Som. Md.		
24. FUNERAL DIRECTOR NAME Leroy G. Webster			25a. DATE REC'D. BY REGISTRAR SEP 9 1985			25b. REGISTRAR'S SIGNATURE Leroy G. Webster					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/cremation permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed and advised.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Please do so as soon as possible.

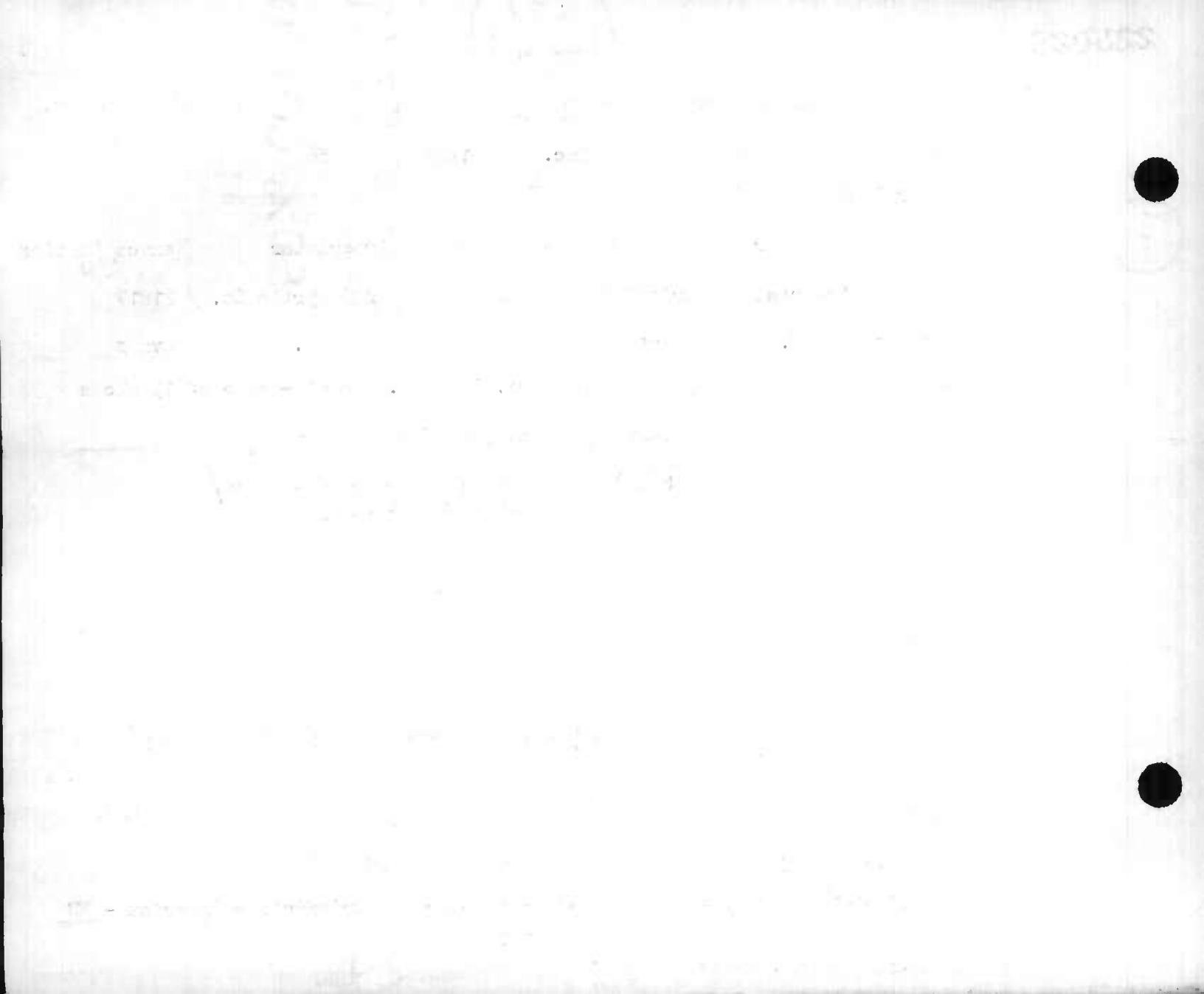
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** Item 21 is marked as Item 18 shows new injury or other traumatic event. The medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/83  
(VRA 15, 4)

I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			REG. NO.	2b. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
William (Spry) Thomas							8-4-85			6:05p.m.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male		white		MONTH DAY YEAR			56			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Maryland		USA					Somerset					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Crisfield		Edw. W. McCready Mem. Hospital		Proprietor			Texaco Station					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
MD		Somerset		Crisfield		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		406 Myrtle St. / 21817				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
FIRST George		MIDDLE M.		LAST Thomas		FIRST Virginia			MIDDLE E.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
Yes		WW II			213-22-4967			Mrs. Sandy O. Thomas - same as 13 abcde			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY												
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>												
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
Pulmonary Circumous w/ metastasis												
DUE TO, OR AS A CONSEQUENCE OF (b) (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET						
22a. I certify that (I) (this hospital) attended the deceased from <u>7/1/85</u> , 19 <u>85</u> , to <u>8-2</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8-2</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/5/85</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
Dr. Evangelista		Main St., Crisfield, Md. 21817										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN						
Burial		8/7/85		Sunnyridge Cemetery		Crisfield - Somerset - MD						
24. FUNERAL DIRECTOR NAME		ADDRESS		21817		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Bradshaw & Sons, Main St., Crisfield, Md.						AUG 9 1985						



242032

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 2 3 8 2 3

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Cela M Tyndall						August	20	1985	5 30 P			
3. SEX			4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			Caucasian	MONTH	DAY	YEAR	86	MONTHS	YEARS	MONTHS	DAY	
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia			U.S.				Somerset					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Princess Anne Manokin Manor Nursing Home						Housewife			None			
13a. STATE (COUNTRY)			13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			
Virginia			Accomac	Parksley		YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	Accomac City Nursing Home 2301				
14. FATHER'S NAME FIRST			MIDDLE	15. MOTHER'S MAIDEN NAME FIRST		LAST						
Unknown Columbus Mears				Unknown Ida Ellick								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO			228-48-5166		Mrs Ruth Thomas			Atlanta, Ga				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Atherosclerotic Heart Disease, Diabetes</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
-						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 26</u> , 19 <u>85</u> , to <u>20 Aug</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>20 Aug</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
William A. Goldsby			MD						8/21/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
William A. Goldsby MD			P.O. Box 40 Mt Vernon Rd Princess Anne, Md 21853									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN			23e. COUNTY			
Burial			8-22-1985	Taylor's Memorial		Temperanceville, Va			Accomac Co			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
						AUG 28 1985			John Anderson Goldsby			

9999 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use at the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF PENDING IN PENN, WRITE THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 7 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201, PRIOR TO BURIAL, CREMATION OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												23824 REG. NO.			
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)									2a. DATE KNOWN OF ESTI- DEATH MATED			
231025			Leroy White									19 M			
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		
male			Black		May 5, 1917		68 yrs.						August 8, 1985 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?									9. BALTIMORE CITY OR COUNTY OF DEATH			
Dames Quarter			USA									Somerset			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Dames Quarter			Home									Waterman (retired)		21820	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		P.O.				
Md.			Somerset		Dames Qtr.						21820				
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
Marshall					Hyland		Mary Frances				White				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.									17. INFORMANT			
Yes			World War II									Milton Wigfall Dames Quarter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BURNS, Total Body Surface</b> 8903 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM		MONTH DAY		YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		TRAILOR CAUGHT FIRE				
12:30 P.M.			8		8		1985								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY STREET, FACTORY, FARM, ETC.		21f. LOCATION CITY OR TOWN		STATE		21g. LOCATION CITY OR TOWN		COUNTY				
AT WORK			Box 80 Dames Quarter		Box 20 Dames Quarter		Somerset		Somerset		Md.				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE <u>M. D. Barhan M.D.</u>			TITLE (SPECIFY) <u>M.D.</u> MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT) <u>M. D. Barhan</u>			ADDRESS <u>Rt. 413, Crisfield, Md 21817</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>8/10/85</u>		23c. NAME OF CEMETERY OR CREMATORIALY <u>Macedonia</u>				23d. LOCATION CITY OR TOWN <u>Dames Quarter, S. Md.</u>		COUNTY STATE				
24. FUNERAL DIRECTOR NAME <u>William H. James III</u>			25a. DATE REC'D. BY REGISTRAR <u>258 Church St, Princess Anne, Md 21853</u>		25b. REGISTRAR'S SIGNATURE <u>John Landon-Randall</u>				AUG 19 1985						
BP															
DHMH - 17 (VR A15 ME (5))															
15M7/77															

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